

Coding Instructions for Confidential Cancer Reporting Form, continued**GENERAL SUMMARY STAGE (760) (ROADS pgs. 137-140)**

The SEER Summary Staging Manual, 2000 (SSSM2k) replaces The Summary Staging Guide 1977 (SSG77). This is a published Self-Instructional Manual for Tumor Registrars, and is a **recommended reference** for the documentation of GENERAL SUMMARY STAGE on the TCR Reporting Form. The Summary Staging Guide 1977 should be used for all cases diagnosed prior to January 01, 2001. The new SEER Summary Staging Manual should be used for cases diagnosed January 01, 2001 and forward. This resource can be obtained from SEER. Web site <http://seer.cancer.gov/Publications> and their mailing address is:

National Cancer Institute
Publication Ordering Service
P. O Box 24128
Baltimore, MD 21227

The TCR no longer requires reporting of AJCC/TNM stage. If you have an ACoS approved cancer program, you must follow their requirements regarding AJCC/TNM staging in order to keep your approval status. The AJCC/TNM stage **cannot** be substituted for the General Summary Stage.

NOTE: SSSM2k **should not** be used for cases diagnosed prior to January 01, 2001.

The General Summary Stage is a summary of the extent of disease categorized as in-situ, localized, regional, and distant.

In-situ (Figure 1) describes a neoplasm that is “noninvasive” and confined to a small circumscribed area within the tissue of origin. There is no penetration of the basement membrane of the tissue and no stromal invasion. An in-situ lesion can only be diagnosed by microscopic examination. Histologic confirmation will be “1”, “2” or “4”.

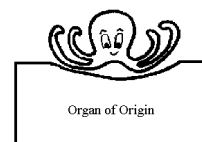


Figure 1

NOTE:

1. If the patient has lymph node metastasis or other metastatic spread the lesion is no longer in- situ.
2. Organs and tissues that have no epithelial layer cannot be staged as in-situ, since they have no basement membrane. There cannot be a diagnosis of “sarcoma in-situ”.

Localized (Figure 2) indicates a neoplasm that has not spread beyond the organ of origin or basement membrane. For a lesion to be classified as “localized”, there must be no extension beyond the outer limits of the primary organ and no evidence of metastasis elsewhere in the body. The tumor may be widely invasive, or even show metastasis within the organ of origin (primary site) and still be considered “localized”.

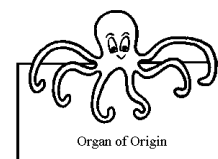


Figure 2

Coding Instructions for Confidential Cancer Reporting Form, continued

Regional (Figure 3) identifies a tumor that has spread to adjacent organs or tissues or to lymph nodes surrounding the primary organ. Lesions that have reached this stage are probably the most difficult to categorize. Two factors are important in assigning cases to this stage: first, it must be established that the cancer is more than localized; and second, remote spread must be reasonably ruled out on the basis of all evidence available in the medical record.

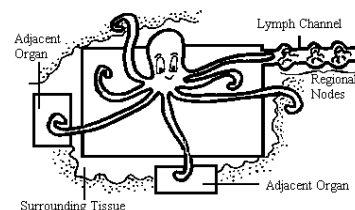
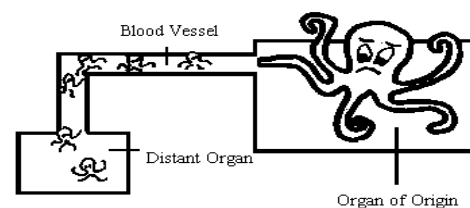


Figure 3

Distant refers to a neoplasm that has extended to remote areas from the primary tumor by metastasis either through the blood system (Figure 4), distant lymph nodes (Figure 5) or by implantation metastasis (Figure 6). Distant stage is also called remote, diffuse, disseminated, metastatic or secondary disease. For more details refer to page 8 of the SSSM2K Manual.



Blood-Borne Metastasis

Figure 4

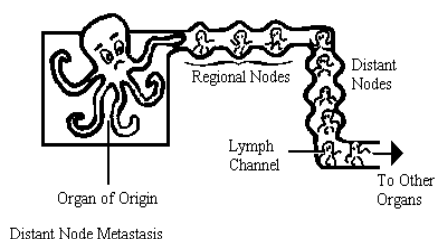
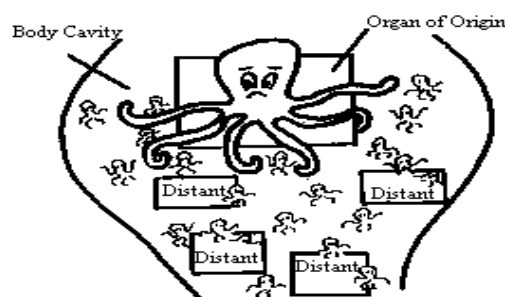


Figure 5



Implantation Metastasis

Figure 6

Unknown is used when there is insufficient information to determine stage or extent of disease. If the primary site is unknown (C80.9), then the Summary Stage must be unknown.

In order for the TCR staff to accurately code stage of disease, all necessary information from the medical record must be documented. Extent of disease is based on a combined clinical and surgical assessment and should include all information available through completion of surgery(ies) in the first course of treatment or within **four months** of diagnosis in the absence of disease progression, which ever is longer. Certain components of the medical record are vital to correctly assess the spread of the tumor. Both positive and negative findings that are pertinent to describing the spread of the tumor from the primary site should be recorded on the reporting form under **STAGING DOCUMENTATION**.

Coding Instructions for Confidential Cancer Reporting Form, continued

NOTE: A major change from the "Summary Staging Guide 1977" to the "SEER Summary Staging Manual 2000" is the change in the "time rule" from "two months" used with SSG77 to the "four months" with the implementation of SSSM2k. **EFFECTIVE WITH 2001 CASES.**

The following list, although not inclusive, contains pertinent pieces of the medical record which are helpful when documenting the staging information:

- ✓ Pathology reports -- contain details on morphology, topography, stage of disease, etc;
- ✓ Operative reports -- may contain information on stage of disease, and origin of tumor;
- ✓ Scans, x-rays, lab tests, & scopes -- may contain information on staging;
- ✓ History and Physical (H&P) -- may contain additional information on race, other tumors, staging information, and primary site; and
- ✓ Discharge summary -- may contain supplemental information on diagnosis treatment, topography and staging information.

If you encounter records in which you cannot adequately determine the appropriate information to document, **attach copies of the necessary reports to the Reporting Form** so TCR staff can determine the correct code. For SCL users, include copies of the necessary reports with your diskette and Transmittal Form. You may also call your regional program for technical assistance.

If your facility has staff experienced in staging, this position may be completed using the codes listed below and the SEER Summary Staging Manual 2000. Otherwise, TCR staff will complete this field based on staging documentation provided.

Codes:

- 0 In Situ
- 1 Localized
- 2 Regional by direct extension
- 3 Regional to lymph nodes
- 4 Regional (direct extension AND lymph nodes)
- 5 Regional, NOS
- 7 Distant metastasis/systemic disease i.e., leukemia, multiple myeloma
- 9 Unstaged, unknown, unspecified

NOTE: *Autocoding of stage is not considered adequate documentation.*

SUMMARY STAGING DOCUMENTATION (2600)

Stage documentation is REQUIRED, even if your facility codes this position. Documentation must be provided from state reporting facilities without an approved cancer program. Facilities approved by the American College of Surgeons without a *documented data quality program* should provide text information.

Refer to guidelines under General Summary Stage. Information such as lymph node involvement, invasion to tissues or organs adjacent to primary site, and spread to distant sites should be included. Document **both the date and source of** staging information. This will help TCR staff to determine if this information can be used to code stage. If little or no information on extent of disease at diagnosis is found in the medical record, enter "*unknown staging information*" or "*no other staging*"

Coding Instructions for Confidential Cancer Reporting Form, continued

information available” in this area. When documenting staging information, be concise, complete, and use abbreviations whenever possible.

Listed below are terms that indicate **tumor involvement**:

<i>adherent</i>	<i>impose/imposing on</i>	<i>protruding into(unless</i>
<i>apparent(ly)</i>	<i>incipient invasion</i>	<i>encapsulated)</i>
<i>appears to</i>	<i>induration</i>	<i>suspect(ed)</i>
<i>comparable with</i>	<i>infringe/infringing</i>	<i>suspicious</i>
<i>compatible with</i>	<i>into</i>	<i>to</i>
<i>consistent with</i>	<i>intrude</i>	<i>typical of/for</i>
<i>contiguous/continuous with</i>	<i>invasion to, into, onto or out</i>	<i>up to</i>
<i>encroaching upon</i>	<i>onto</i>	<i>organomegaly</i>
<i>extension to, into, onto, or</i>	<i>most likely</i>	<i>visceromegaly</i>
<i>out onto</i>	<i>onto</i>	<i>ascites (malignant)</i>
<i>favor</i>	<i>out onto</i>	<i>pleural effusion (malignant)</i>
<i>features of</i>	<i>overstep</i>	
<i>fixation, fixed</i>	<i>presumed</i>	
<i>impending perforation of</i>	<i>probable</i>	
<i>impinging upon</i>	<i>masses</i>	
	<i>induration</i>	

Terms that **do not** constitute involvement:

<i>abuts</i>	<i>invasion/involvement of</i>
<i>approaching</i>	<i>matted (except for lymph nodes)</i>
<i>approximates</i>	<i>kiss(ing)</i>
<i>attached</i>	<i>possible</i>
<i>cannot be excluded or ruled out</i>	<i>questionable</i>
<i>efface</i>	<i>reaching</i>
<i>encased</i>	<i>rule out</i>
<i>encasing</i>	<i>suggests</i>
<i>encompass(ed)</i>	<i>very close to</i>
<i>entrapped</i>	<i>worrisome</i>
<i>equivocal</i>	
<i>extension to without</i>	

Coding Instructions for Confidential Cancer Reporting Form, continued

The terms “*entrapped*” and “*encased*” should not be interpreted as involvement in the absence of other evidence to indicate there was involvement.

Terms indicating in-situ:

Adenocarcinoma in an adenomatous polyp with no invasion of stalk

Bowen’s Disease

Clark’s Level I for melanoma (limited to epithelium)

Comedocarcinoma, noninfiltrating

Confined to epithelium

Hutchinson’s melanotic freckle, NOS

Intracystic, non-infiltrating

Intraductal

Intraepidermal

Intraepithelial

Intrasquamous

Involvement up to but not including the basement membrane

Lentigo maligna

Lobular neoplasia

Lobular, noninfiltrating

No stromal invasion

Non-infiltrating

Non-invasive

Papillary, noninfiltrating or intraductal

Precancerous melanosis

Preinvasive

Queyrat’s erythroplasia

Stage 0

NOTE: Remember that there has to be microscopic confirmation (“1”, “2” or “4”) to assign an in situ stage.

The following terms or conditions are indicative of *distant* or *discontinuous* metastasis:

ascites (malignant)

carcinomatosis

implantation

implants

pleural effusion (malignant)

seeding

studding

NOTE: When abstracting please do not document or code ascites and/or pleural effusions which are not malignant and due to comorbid conditions.

Coding Instructions for Confidential Cancer Reporting Form, continued

Document staging information, using standard abbreviations whenever possible, as follows:

- ✓ Both negative and positive findings from radiology reports, i.e. CT BRAIN-NEMD; CXR-neg; MRI ABD-no evid of mets; CT ABD-liver mets; BONE SCAN-incr uptake c/w mets.
- ✓ Lymph node (ln) involvement, i.e. reg ln invlvd; 12 ax nodes +; no mets to examined reg ln.
- ✓ Invasion to tissues/organs adjacent to primary site, i.e. breast tmr invading chest wall; malignant melanoma deeply invasive to subq tissues.
- ✓ Any distant metastasis, i.e. liver mets; brain mets; bone mets.
- ✓ Significant lab values, i.e., elevated calcium, alkaline phosphatase, LDH, any tumor markers (such as ER/PR, CEA, CA 19-9, CA 125).

Lymph Nodes: For solid tumors, the terms “fixed” or “matted” and “mass in the mediastinum, retroperitoneum, and/or mesentery” (with no specific information as to tissue involved) are considered involvement of lymph nodes. Any other terms, such as “palpable”, “enlarged”, “visibly swelling”, “shotty”, or “lymphadenopathy” should be ignored; look for a statement of involvement, either clinical or pathological.

A metastatic nodule in connective tissue of a lymph drainage area is considered to be evidence of lymph node metastasis.

If a specific lymph node chain is not listed among the regional lymph nodes (in the SEER Summary Staging Manual 2000), it should be considered a distant metastasis if it is involved.

NOTE: Regional lymph nodes are not palpable for inaccessible sites such as bladder, kidney, prostate, esophagus, stomach, lung, liver, corpus uteri and ovary. The best description concerning regional lymph nodes will be the surgeons’s evaluation at the time of exploratory surgery or definitive surgery.

Venous Invasion: *Venous invasion* is an assessment of blood vessels **within** the primary organ. This does not constitute regional or distant spread of malignancy.

Lymphatic Invasion: *Lymphatic invasion* is a microscopic assessment of involvement of the lymphatic channels **within** the primary organ and at the margins of resection. This is an assessment of the potential, from the primary tumor, to metastasize to lymph nodes, even though the tumor has extended no further than the lymph channels and is still confined to the primary site.

Residual Tumor: *Residual tumor* refers to the status of the margins after a surgical procedure of the primary site. It is important to document this information if it is available in the pathology and/or operative report.

Microscopic residual tumor is that which is identified by the pathologist through the microscope but which is not apparent visually. An example would be a positive margin of resection when the surgeon stated that the tumor was completely removed.

Coding Instructions for Confidential Cancer Reporting Form, continued

Macroscopic residual tumor is identified during the procedure by the surgeon and is tumor that is grossly visualized. An example of this would be tumor adhering to another structure that the surgeon could not remove.

Lymphomas: For lymphomas, **any** mention of lymph nodes is indicative of involvement.

In staging lymphomas, bilateral node involvement should be considered 2 chains for the purpose of assigning a stage. For example, bilateral inguinal nodes, bilateral iliac nodes, etc., would be considered 2 chains.

NOTE: When there is doubt about assigning the appropriate stage, assign the lesser stage. Do not over stage.

The following are scenarios with examples of how to document staging information. Sites included are bladder, breast, colon, lung, and prostate.

Bladder (Figure 7 and Figure 8)

Staging information can be obtained from any of the following:

- ▶ Histologic confirmation of tumor, by histologic or urinary cytology
 - ▶ Bimanual examination under anesthesia before and after endoscopy
 - ▶ Cystoscopy
 - ▶ Pyelography
 - ▶ Imaging (radiographic and computer assisted)
 - ▶ Other evaluations to determine metastatic involvement, including CT scans, biochemical studies and isotope studies or
 - ▶ Total cystectomy and lymph node resection
1. Cystoscopy was positive on 2-1-01 for transitional cell carcinoma of the bladder. A CT scan of the pelvis noted a bladder tumor extending into perivesical fat. No lymphadenopathy identified. Pathology report from the total cystectomy and lymph node dissection on 2-2-01 noted the tumor extended into the perivesical fat with 4 positive para-aortic lymph nodes all less than 2cm in size.

Document: 2-1-01 cysto + for trans cell ca. CT Pelv-blDDR tmr ext into perivesical fat. 2-2-01 cystectomy-tmr ext into perivesical fat w/4 + para-aortic lns.

2. Biopsies taken during cystoscopic examination on 2-1-01 indicated a tumor of the bladder extending superficially into the subepithelial connective tissue. Bimanual examination revealed enlarged pelvic nodes. Patient underwent a total cystectomy and regional node dissection on 2-2-01. The path report revealed the tumor extended through the bladder wall into surrounding connective tissue and all nodes were negative.

Document: 2-1-01 cysto-blDDR tmr ext superficially into subepi conn tiss. Biman Exm-enlrgd pelv nodes. 2-2-01 cystectomy-tmr ext thru blDDR wall into surrounding conn tiss. All lns neg.

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3. Patient presented with hematuria. Multiple tumors were removed during cystoscopy on 3-1-01, all positive for Grade II transitional cell carcinoma. No other staging information available.

Document: 3-1-01 multi tmrs were rmvd during cysto, + for grd II trans cell ca. Other w/u N/A.

4. 75yo male admitted for cystoscopy on 2-20-01 which was positive for transitional cell carcinoma of the bladder. CT of the pelvis noted a large tumor of the bladder with extension to the rectum and probable pathologic common iliac nodes.

Document: 2-20-01 cysto + trans cell bladder. CT Pelv-lg blddr tmr w/ext to rectum & prob pathologic common iliac nodes.

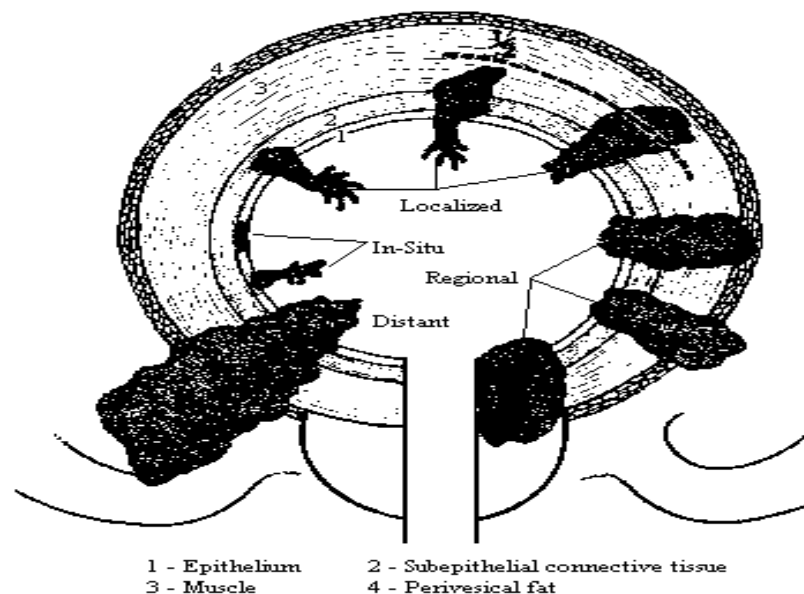
BLADDER

Figure 7 Source: Workbook for Staging of Cancer with modifications

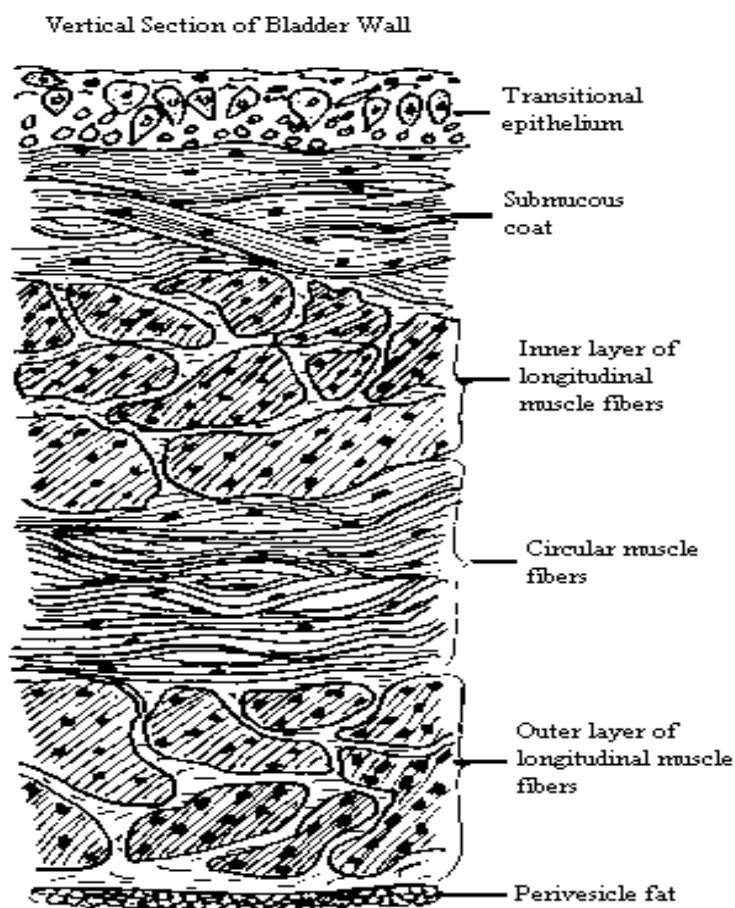
Coding Instructions for Confidential Cancer Reporting Form, continued

Figure 8 Source: SEER Informational Guidebook, Training Aids

Coding Instructions for Confidential Cancer Reporting Form, continued

Breast (Figure 9 and Figure 10)

Staging information can be obtained from any of the following:

- ▶ Physical examination
- ▶ Pathologic examination of breast or other tissue to establish a diagnosis of cancer
- ▶ Operative findings, including the size of tumor, chest wall invasion, and presence or absence of positive nodes and distant metastasis
- ▶ Imaging to establish the extent of cancer. Useful studies: mammogram, chest x-ray, bone scan, metastatic skeletal x-rays, brain scan, liver/spleen scan, CT scans, MRI
- ▶ Nodules of tumor in the fat adjacent to the primary tumor are considered regional lymph node metastasis (intramammary nodes); or
- ▶ Clusters or clumps of cancer cells found in axillary fat that are not specifically identified as lymph nodes are considered to be axillary lymph nodes that have lost their architectural configuration

1. Patient was noted to have a 4x4 cm hard mass in the upper inner quadrant of the left breast with skin dimpling and peau d'orange and palpable nodes in the axilla. Biopsy was positive for infiltrating ductal carcinoma, poorly differentiated on 2-20-01. Patient underwent a modified radical mastectomy on 2-20-01. Pathology report noted a 3x3 cm mass with skin infiltration and 4/15 positive lymph nodes all smaller than 1cm.

Document: hard mass UIQ lt breast w/skin dimpling, peau d'orange & palp nodes in axilla. 2-20-01 path rpt: 3x3cm mass w/skin infiltration & 4/15 + ax nodes.

2. A 2cm lesion in the UOQ of the right breast was noted on physical exam. Right supraclavicular nodes were enlarged. The breast mass was excised and the supraclavicular nodes were biopsied 2-17-01. Both specimens were positive for poorly differentiated infiltrating ductal carcinoma.

Document: 2cm les RUOQ breast w/enlrgd rt SC nodes. Bx rt breast & SC nodes pos for PD infiltr duct ca 2-17-01.

3. Biopsy was positive for intraductal carcinoma of the left breast on 2-15-01, with a small focus of invasive component. Patient underwent a lumpectomy and axillary node dissection on 2-16-01. The lumpectomy was negative for residual disease and all 10 nodes were negative for disease.

Document: 2-15-01 Bx pos for intraductal ca lt breast w/sm focus of inv. 2-16-01 lumpectomy neg for residual dz, 10 nodes neg.

4. A 2.5cm tumor in the LIQ was noted on physical exam. The pathology report from the biopsy on 2-15-01 showed infiltrating ductal carcinoma. A modified radical mastectomy was performed on 2-15-01. There was no residual tumor at the biopsy site at the time of mastectomy, 3/19 nodes were positive for tumor.

Document: 2-15-01 Bx infiltr ductal ca. 2-15-01 MRM-no resid ca. 3/19 node pos for tumor.

5. A large 5cm mass of the right upper outer quadrant was noted with no palpable axillary lymphadenopathy. At mastectomy on 3-1-01, the tumor was noted to involve the chest wall and 4/18 positive axillary nodes were positive, the largest of which was greater than 2cm.

Document: 5cm mss RUOQ. 3-1-01 path-tmr invlvd chest wall, 4/18 nodes +.

Coding Instructions for Confidential Cancer Reporting Form, continued

BREAST

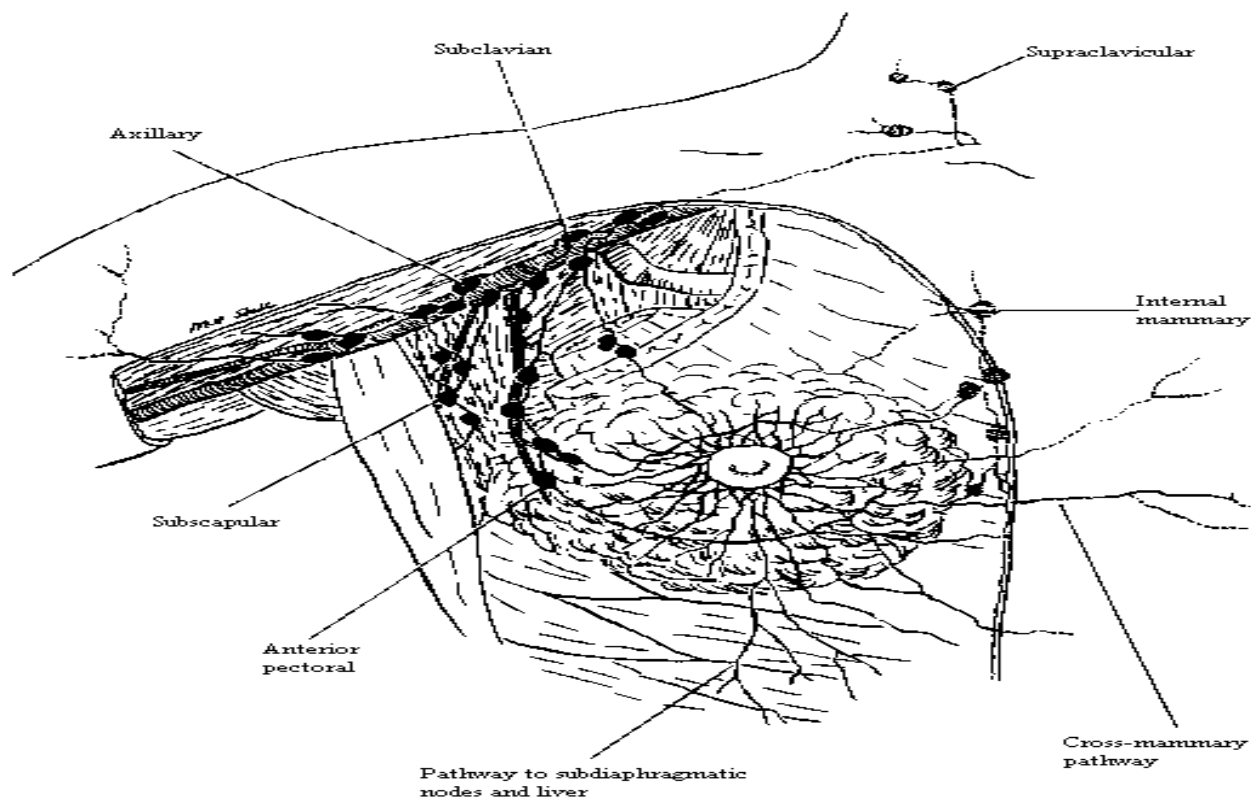


Figure 9 Source: Cancer Patient Data Program, Research and Training, University of California @ San Francisco.

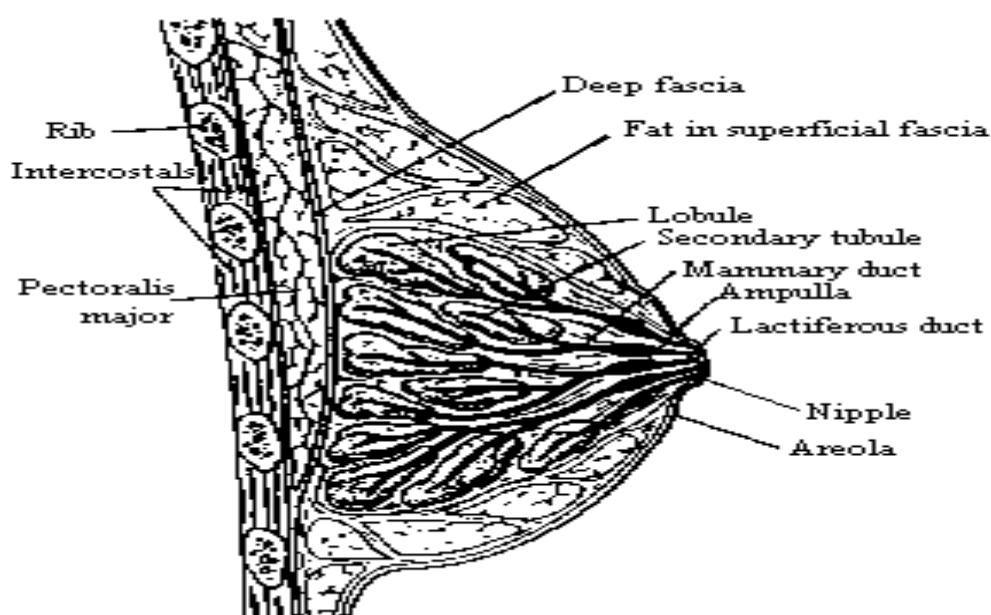


Figure 10 Source: SEER Self Instructional Manual for Tumor Registrars, Book 4

Coding Instructions for Confidential Cancer Reporting Form, continued

Colon (Figure 11 and Figure 12)

NOTE: The colon is a hollow organ. Staging is based on depth of invasion rather than size of tumor. Look for terms like submucosa, muscularis propria, and serosa.

Staging information can be obtained from any of the following;

- ▶ Physical examination, including digital rectal examination as appropriate
- ▶ Barium enema
- ▶ Endoscopy (sigmoidoscopy, colonoscopy) and biopsy; cystoscopy
- ▶ Evaluations for possible metastasis. Special studies include: chest x-ray, small bowel series, liver/spleen scan, abdominal and pelvic CT scans, MRI, brain and bone scans
- ▶ Pathologic examination of the resected specimen
- ▶ Exploration and surgical observation of the abdomen; or
- ▶ Nodules of tumor in pericolic or perirectal fat are considered to be lymph nodes containing metastasis

1. Segmental resection of the sigmoid colon on 2-1-01 revealed infiltrating grade II adenocarcinoma w/invasion of the serosa and 4 lymph nodes positive for metastasis.

Document: 2-1-01 Path-infilt grd II adenoca w/inv of serosa & 4 lymph nodes pos.

2. Polypectomy specimen on 2-27-01 revealed grade II adenocarcinoma arising in an adenomatous polyp. No invasion of submucosa of the stalk was identified.

Document: 2-27-01 polypectomy-adenoca arising in adenomatous polyp, no inv of stalk identified.

3. Hemicolectomy on 2-20-01 revealed a grade III infiltrating adenocarcinoma extending into but not through the muscularis propria. At least 20 pericolic lymph nodes were negative for tumor.

Document: 2-20-01 path rvld grd 3 adenoca ext into but not thru muscularis propria. 20 pericolic ln neg for tmr.

4. Adenocarcinoma of the hepatic flexure extending through the bowel wall into adjacent tissue, onto the surface of the liver with 3 of 10 lymph nodes positive for adenocarcinoma on 3-1-01. En bloc resection of the liver revealed metastatic adenocarcinoma of the liver capsule.

Document: 3-1-01 adenoca hep flex ext thru bowel wall onto surface of liver. 3/10 ln pos. En bloc resection liver rvld mets of liver capsule.

Coding Instructions for Confidential Cancer Reporting Form, continued

COLON

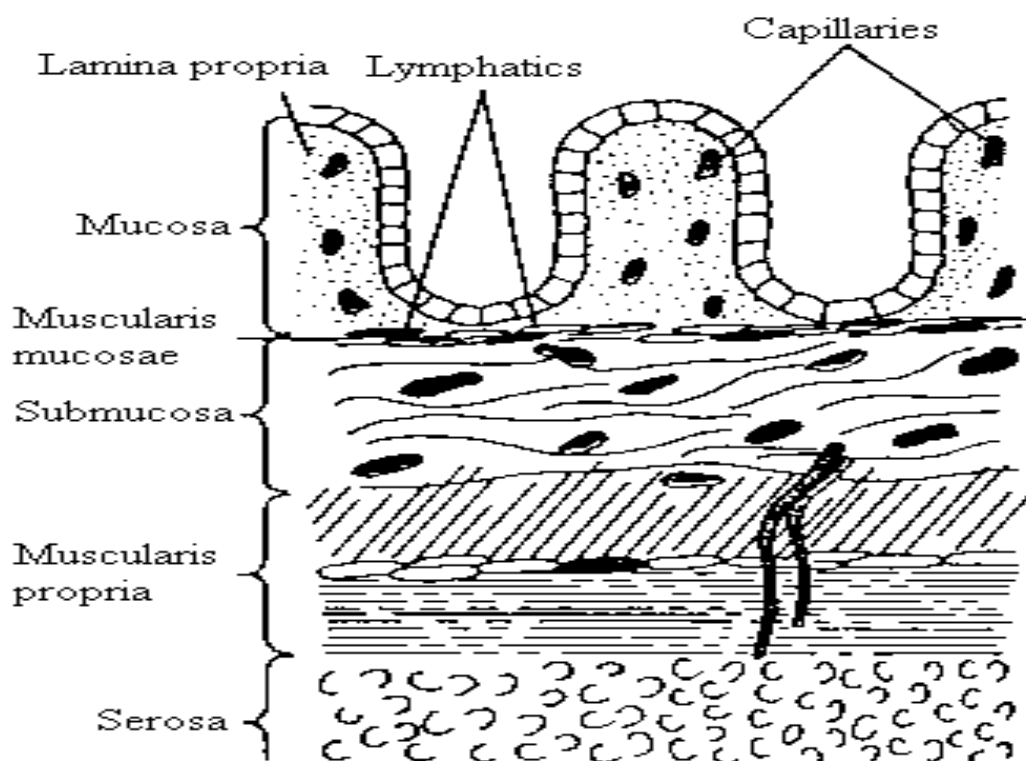


Figure 11

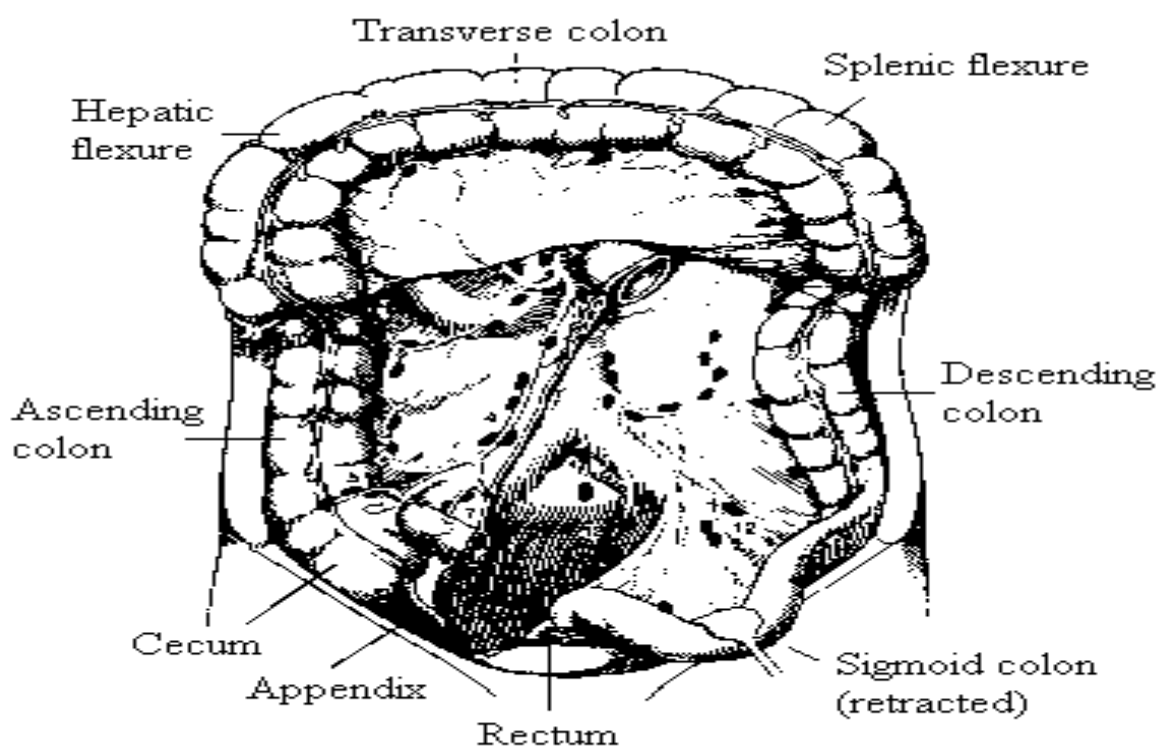


Figure 12 Source: Workbook for Staging of Cancer

Coding Instructions for Confidential Cancer Reporting Form, continued

Lung (Figure 13)

Staging information can be obtained from any of the following:

- ▶ Physical examination;
- ▶ Pathologic examination of primary tumor or other tissue to establish a diagnosis of cancer, such as fine needle biopsy and cytology, sputum cytology, bronchial washings, thoracentesis;
- ▶ Imaging, such as chest x-ray, lung scan, CT chest, lung tomography, MRI scan of the lung;
- ▶ Endoscopy, such as bronchoscopy, mediastinoscopy, thorascopy;
- ▶ Studies to determine presence or absence of positive nodes and distant metastasis. Useful studies include bone scan, brain scan, liver/spleen scan, esophagogram, esophagoscopy, laryngoscopy, and bone marrow biopsy;
- ▶ Mediastinotomy;
- ▶ Information from thoracotomy; or
- ▶ Pathological examination of the resected specimen and lymph nodes.

NOTE: Assume mediastinal nodes are involved if a mediastinal mass or mediastinal adenopathy are reported on x-ray or mediastinoscopy.

1. CT scan of the chest noted a small tumor in the right main stem bronchus 3 cm from the carina with negative hilar and mediastinal nodes. Enlarged cervical nodes were noted on physical exam. Biopsy of a cervical node was positive for adenocarcinoma on 3-1-01.

Document: CT Chest-sm tmr rt mnstm bronchus, neg hilar/mediast nodes. Enlrgd cerv nodes on PE. 3-1-01 bx cerv nodes pos for adenoca.

2. CXR demonstrated a tumor in the left lower lobe of the lung with pleural effusion and positive bilateral paratracheal nodes. Cytology of the pleural fluid on 2-17-01 was positive for squamous cell carcinoma.

Document: CXR-tmr LLL w/pl eff & pos bil paratrach nodes. 2-17-01 cytology of pl fld pos for SCC.

3. A 3cm tumor was noted on CXR. A lobectomy was performed on 2-17-01 and pathology was positive for a 3.5cm adenocarcinoma of the right lung with microscopic extension to the carina and 4 out of 10 hilar nodes were positive for adenocarcinoma.

Document: CXR-3cm tmr. 2-17-01 path-3.5cm adenoca Rt lung w/microscopic ext to carina. 4/10 hilar nodes pos.

4. A CT of the chest revealed a 2cm tumor in the right lung with enlarged right subcarinal lymph nodes. Biopsy subcarinal nodes were positive for large cell carcinoma on 2-19-01.

Document: CT Chest-2cm tmr Rt lung w/enlrgd Rt subcarinal lns. 2-19-01 bx SC nodes + for lg cell ca.

Coding Instructions for Confidential Cancer Reporting Form, continued

5. CXR noted a 2.5cm tumor of the LLL of the lung. The resected specimen from the lobectomy showed invasion of the visceral pleura on 2-16-01. All nodes were negative for tumor.

Document: CXR-2.5cm tmr LLL. 2-16-01 lobectomy-inv visc pleura. Nodes -.

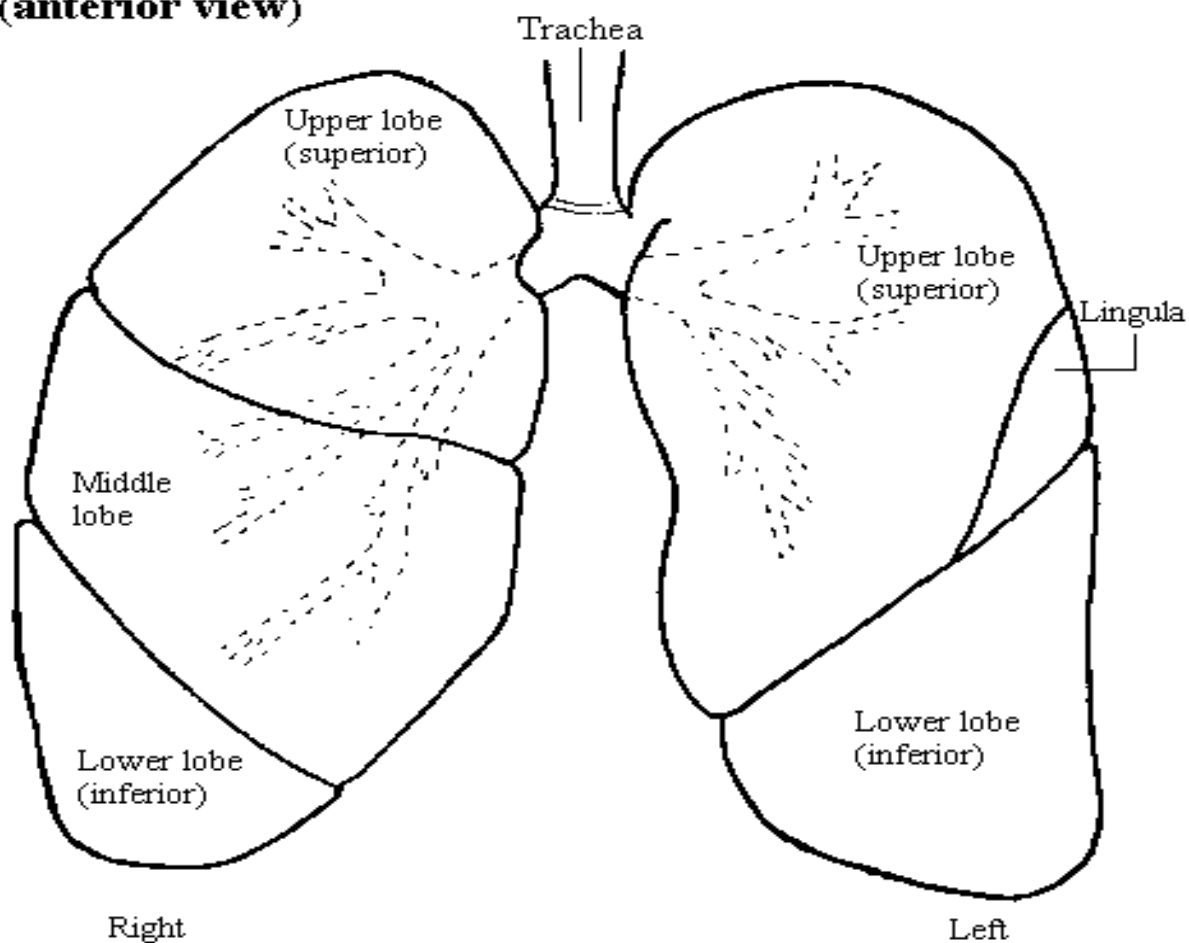
**Lung, Bronchus, Trachea
(anterior view)**

Figure 13 Source: SEER Informational Guidebook Training Aids

Coding Instructions for Confidential Cancer Reporting Form, continued

Prostate (Figure 14)

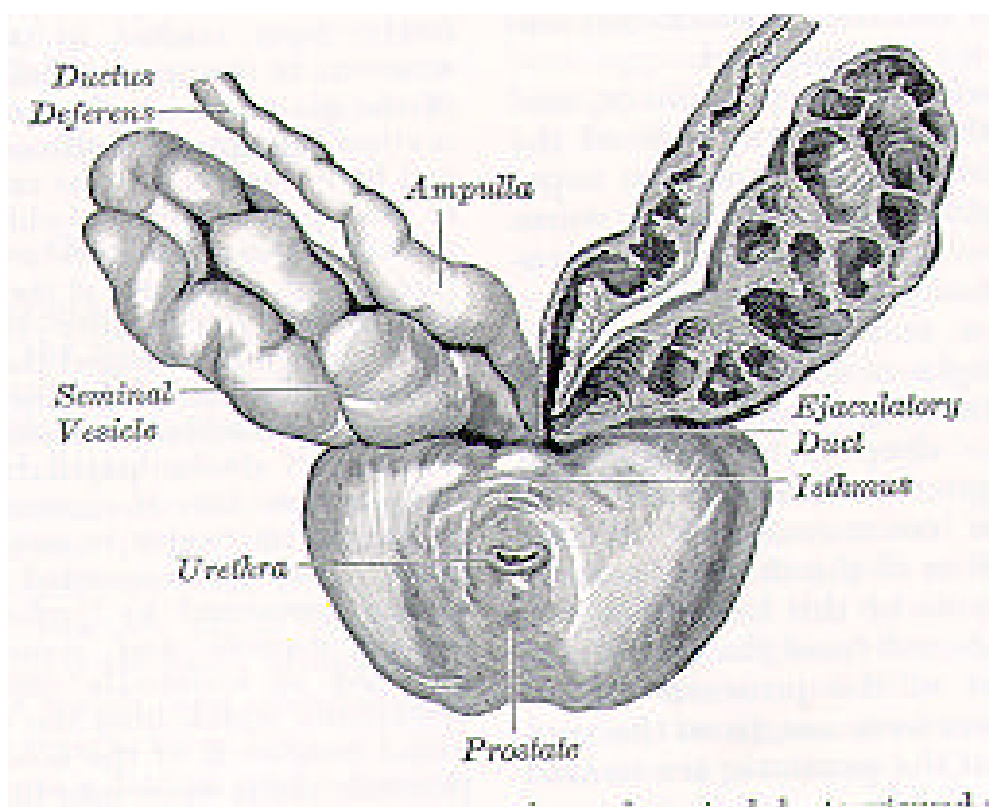
Staging information can be obtained from any of the following:

- ▶ Proof of malignancy by histology or cytology;
 - ▶ Digital rectal exam;
 - ▶ Imaging, including transrectal ultrasound, intravenous pyelogram, kidney-ureter-bladder x-ray, abdominal and/or pelvic CT scans, lymphangiogram, MRI;
 - ▶ Endoscopy, including cystoscopy, proctosigmoidoscopy;
 - ▶ Evaluations for possible metastasis, including chest x-ray, bone scan, metastatic bone survey, brain scan, liver/spleen scan;
 - ▶ Laboratory tests, including acid phosphatase and prostate-specific antigen (PSA), and other tumor markers as appropriate; or
 - ▶ Total removal of the prostate and seminal vesicles (prostatoseminalvesiculectomy) as well as a pelvic lymph node dissection.
1. On rectal exam, the prostate was noted to be slightly enlarged without induration. CT of the pelvis was negative. The path report from the TURP on 2-15-01 states: “moderately well differentiated adenocarcinoma of the prostate with slight perineural invasion.”

Document: RE-sl enlrgd prostate w/o induration. CT Pelv-neg. 2-15-01 TURP-mwd adenoca w/sl perineural inv.

2. Patient presented with a nodule occupying more than half a lobe of the prostate but seemed confined to the prostate on rectal exam. A needle biopsy was positive for adenocarcinoma on 2-16-01. The pathology from the radical prostatectomy on 2-16-01 noted extension into the right seminal vesicle. All nodes were negative.

Document: Nodule occupying > ½ lobe of prost w/o evid of ext outside of prost. 2-16-01 Needle bx + for adenoca. 2-16-01 prostatectomy/lymphadenectomy-ext to R sem ves noted, all nodes (-).

Coding Instructions for Confidential Cancer Reporting Form, continued**PROSTATE****Figure 14**